

VSP Signature Plan® Proposal

Prepared for Connexion 2021



The VSP Signature Plan is a premier full-service plan that offers the lowest costs, a focus on health, and real provider choices.

Guaranteed Lowest Out-of-Pocket Costs

Our Member Promise guarantees that employees are completely satisfied with their eye care and eyewear from VSP network providers, or we'll make it right. This includes satisfaction with out-of-pocket costs, consumer's #1 priority in a vision plan. We guarantee your employees will have the lowest out-of-pocket costs for equivalent glasses with VSP network providers, compared to your current vision plan, if applicable. One of the ways we reduce patient out-of-pocket costs is by applying fixed copays toward lens enhancements. We're also covering standard progressives with no additional copay. Unlike most competing vision plans, we also offer a wholesale frame pricing guarantee allowing us to cover more frames.

A Focus on Health – VSP Healthy Innovations

Your benefit includes VSP Healthy Innovations, a total wellness solution that leverages the power of a VSP WellVision® exam to see beyond eye health issues. Taking this wholistic approach helps identify signs of chronic conditions before they become serious, saving you money and helping your employees manage their health. This year we're even more focused on helping our members with diabetes and pre-diabetes. VSP doctors are often the first to detect chronic conditions—before other healthcare providers—including diabetes 34% of the time. Members identified in our system as having diabetes receive a complimentary reminder letter from us 14 months after their last eye exam. Every year, we see an average of 22% of these members then scheduling and receiving an exam.

Real Provider Choices

Your employees can choose their provider from **94,000 access points**, including the largest national network of independent doctors and nearly 22,000 participating retail chain access points.

VSP Doctors - 91% offer early morning, evening and weekend appointments. 24-hour access to emergency care.

Retail Chains¹ - Your employees get the convenience of popular retail chains like these and more.



VSP Benefits subject to applicable copays²

Exam Services	Comprehensive WellVision Exam® covered-in-full after copay		
	Contact lens exam - fitting and evaluation (when choosing contacts): Standard and Premium fit : Covered-in-full with a copay. Member receives 15% off ³ of contact lens exam services; ⁴ member's copay will never exceed \$60		
	Routine retinal screening covered after an up to \$39 copay ³		
Lenses	Glass or plastic:	Single vision	Covered-in-full after copay
		Lined bifocal	Covered-in-full after copay
		Lined trifocal	Covered-in-full after copay
		Lenticular	Covered-in-full after copay
Frame	<ul style="list-style-type: none">• Frames covered-in-full after copay up to the retail allowance of \$130⁵• Frame allowance is guaranteed by a \$50 wholesale allowance at VSP doctors, ensuring nearly 12,000 frames are covered-in-full• Members who select a featured frame brand including bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more will receive an extra \$20 toward their frame allowance⁶• 20% off³ any amount above the retail frame allowance⁴• Members can choose from virtually any frame on the market		

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Lens Enhancements	All lens enhancements are covered after a copay, saving members an average of 35-40%. ⁴ Maximum copay on some of our popular lens enhancements:		
	Lens Enhancement	Single Vision	Multifocal
	Standard progressives plastic	N/A	No copay
	Premium progressives plastic	N/A	\$80-90
	Custom progressives plastic	N/A	\$120-160
	Standard anti-reflective coating	\$37	\$37
	Solid tints & dyes (pink I&II)	No copay	No copay
	Solid plastic dye (except pink I&II)	\$13	\$13
	Plastic gradient dye	\$15	\$15
	UV protection	\$14	\$14
	Factory applied scratch-resistant coating	\$15	\$15
		No copay	No copay
	Polycarbonate for children	\$23	\$28
	Polycarbonate	\$62	\$76
	Photochromic plastic		
Elective Contact Lenses (instead of lenses & frame)	<ul style="list-style-type: none"> ● Prescription contact lens materials covered-in-full up to \$130 retail allowance ● VSP members get exclusive mail-in savings⁷ on eligible contacts at VSP doctors ● Members can choose from any available prescription contact lens materials 		
Necessary Contact Lenses (instead of lenses & frame)	<ul style="list-style-type: none"> ● Covered-in-full after copay for members who have specific conditions at VSP doctors ● Covered up to \$210 after copay for members who have specific conditions at participating retail chains 		
Additional Pairs of Glasses	<ul style="list-style-type: none"> ● 30% off³ unlimited additional pairs of prescription glasses and/or non-prescription sunglasses⁸ at VSP doctors ● 20%³ off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses⁸ at participating retail chains 		
Sunglasses	Members who have had laser surgery can use frame benefit for non-prescription sunglasses at VSP doctors		
Primary EyeCare ProgramSM	Supplemental coverage for non-surgical medical eye conditions, such as pink eye and other urgent eye care - \$20 copay ⁹ per visit at VSP doctors		
Laser VisionCare ProgramSM	Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, and Custom LASIK ¹⁰ through VSP doctors		
Low Vision	Supplemental testing covered every two years. 75% coverage for approved low vision aids, up to \$1,000 (less any amount paid for supplemental testing) every two years at VSP doctors		
Eye Health Management Program[®]	Exam reminder letters sent to VSP members with diabetes who have not had an eye exam in 14 months		

Out-of-Network Benefits subject to applicable copays²

Exam	Reimbursed up to \$50	Frame	Reimbursed up to \$70
Lenses:		Contact lens exam & materials (in lieu of lenses & frame):	
Single vision	Reimbursed up to \$50		
Lined bifocal	Reimbursed up to \$75		
Lined trifocal	Reimbursed up to \$100	Elective	Reimbursed up to \$105 ¹¹
Lenticular	Reimbursed up to \$125	Necessary	Reimbursed up to \$210

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Exclusions¹²

There may be some materials and services with either limited or no coverage under this plan. Please contact your VSP representative for more information.

¹ Participating retail chains upon request. Benefits may vary at participating retail chain locations.

² When covered-in-full services are obtained from a VSP network provider, the patient will have no out-of-pocket expense other than any applicable copays. Services and eyewear obtained through out-of-network providers are subject to product availability and the same copays and limitations. Please refer to rate page.

³ Based on applicable laws, benefits may vary by location.

⁴ Walmart and Costco published prices already include discounts instead of those noted.

⁵ Walmart and Costco allowance of \$70 is equivalent to the frame allowance at other VSP network providers.

⁶ Reflects current promotion, evaluated annually. Promotion/featured frame brands are subject to change and the promotional allowance does not apply at Walmart and Costco. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

⁷ Rebates subject to change.

⁸ 30% off applies to glasses purchased the same day as the member's eye exam from the same VSP doctor who provided the exam. Members also receive 20% off unlimited additional pairs of glasses valid through any VSP network provider within 12 months of the last covered eye exam.

⁹ The VSP Primary EyeCare Plan pays secondary to other medical eye insurance coverage.

¹⁰ Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. LaserVisionCare discounts are only available from VSP-contracted facilities.

¹¹ If \$100 allowance is purchased, out-of-network providers will reimburse up to \$85.

¹² Coverage shall be governed solely by the terms of your VSP contract.

VSP SIGNATURE PLAN®
COMMERCIAL BUSINESS RATES
 5-99 Enrolled Employees
 For Clients Headquartered in Washington
 Valid Until December 1, 2021



Prepared for Connexion 2021

Plan Guidelines

- Individual Experience is not available for Pooled Groups
- 24 month rate guarantee and contract term
- These rates assume a minimum employer contribution of 75% toward employees and dependents or 100% participation of employees and dependents enrolled in the medical or dental plan
- Rates are based on our sliding 10% commission scale and the agreement that VSP will receive these amounts over the full plan term
- Platform participation and associated fees are not included
- The first copay applies to the eye examination and the second copay applies to materials
- Rates include all applicable taxes and health assessment fees known as of the date of the proposal

Plan Frequencies

	PLAN C	PLAN B	PLAN A
Eye Exam	12 Months	12 Months	12 Months
Lens	12 Months	12 Months	24 Months
Frame	12 Months	24 Months	24 Months

The difference in the following plans is the intervals when services are available, as shown above. The base rates quoted reflect VSP's standard in-network retail allowances of \$130 for frames and \$130 for elective contact lenses. The 12/12/12 option includes tinted or photochromic lenses at no extra cost.

MONTHLY RATES

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN C Copay: \$10/\$20	\$8.35	\$13.36	\$13.64	\$21.99
\$150.00 Elective Contact Lens Allowance	\$0.33	\$0.53	\$0.54	\$0.86
\$150.00 Retail Frame Allowance	\$0.33	\$0.53	\$0.54	\$0.87
Total:	\$9.01	\$14.42	\$14.72	\$23.72

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN C Copay: \$10/\$25	\$8.00	\$12.80	\$13.07	\$21.07
\$150.00 Elective Contact Lens Allowance	\$0.31	\$0.51	\$0.52	\$0.83
\$150.00 Retail Frame Allowance	\$0.32	\$0.50	\$0.51	\$0.83
Total:	\$8.63	\$13.81	\$14.10	\$22.73

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: \$10/\$20	\$6.73	\$10.76	\$10.98	\$17.71
\$150.00 Elective Contact Lens Allowance	\$0.27	\$0.43	\$0.44	\$0.69
\$150.00 Retail Frame Allowance	\$0.26	\$0.42	\$0.43	\$0.70
Total:	\$7.26	\$11.61	\$11.85	\$19.10

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: \$10/\$25	\$6.44	\$10.31	\$10.52	\$16.96
\$150.00 Elective Contact Lens Allowance	\$0.26	\$0.40	\$0.42	\$0.67
\$150.00 Retail Frame Allowance	\$0.25	\$0.41	\$0.41	\$0.67
Total:	\$6.95	\$11.12	\$11.35	\$18.30

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VSP SIGNATURE PLAN®
COMMERCIAL BUSINESS RATES
 Voluntary Participation 0-24% Employer Paid
 10-50 Enrolled Employees
 For Clients Headquartered in Washington
 Valid Until December 1, 2021



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Plan Guidelines

- Individual Experience is not available for Pooled Groups
- 24 month rate guarantee and contract term
- These voluntary pooled rates are based on enrollment of 10-50 employees
- Rates are based on our sliding 10% commission scale and the agreement that VSP will receive these amounts over the full plan term
- Platform participation and associated fees are not included
- The first copay applies to the eye examination and the second copay applies to materials
- Rates include all applicable taxes and health assessment fees known as of the date of the proposal

Plan Frequencies

	PLAN C	PLAN B
Eye Exam	12 Months	12 Months
Lens	12 Months	12 Months
Frame	12 Months	24 Months

The difference in the following plans is the intervals when services are available, as shown above. The base rates quoted reflect VSP's standard in-network retail allowances of \$130 for frames and \$130 for elective contact lenses. The 12/12/12 option includes tinted or photochromic lenses at no extra cost.

MONTHLY RATES

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN C Copay: \$10/\$20	\$11.87	\$18.99	\$19.39	\$31.25
\$150.00 Elective Contact Lens Allowance	\$0.47	\$0.76	\$0.77	\$1.26
\$150.00 Retail Frame Allowance	\$0.48	\$0.76	\$0.78	\$1.25
Total:	\$12.82	\$20.51	\$20.94	\$33.76

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN C Copay: \$10/\$25	\$11.36	\$18.18	\$18.56	\$29.92
\$150.00 Elective Contact Lens Allowance	\$0.45	\$0.73	\$0.75	\$1.20
\$150.00 Retail Frame Allowance	\$0.46	\$0.73	\$0.74	\$1.20
Total:	\$12.27	\$19.64	\$20.05	\$32.32

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: \$10/\$20	\$9.56	\$15.29	\$15.61	\$25.17
\$150.00 Elective Contact Lens Allowance	\$0.38	\$0.62	\$0.62	\$1.01
\$150.00 Retail Frame Allowance	\$0.38	\$0.61	\$0.63	\$1.01
Total:	\$10.32	\$16.52	\$16.86	\$27.19

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: \$10/\$25	\$9.18	\$14.69	\$14.99	\$24.17
\$150.00 Elective Contact Lens Allowance	\$0.36	\$0.58	\$0.60	\$0.97
\$150.00 Retail Frame Allowance	\$0.37	\$0.59	\$0.60	\$0.97
Total:	\$9.91	\$15.86	\$16.19	\$26.11

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